Letter of Interest to Participate / Application for Membership

Note: The information contained in this application is considered confidential and will not be available to the public. The information will be used for the purpose of fulfilling consortium requirements outlined through Nebraska Health & Human Services Cooperative Agreements with the Centers for Disease Control & Prevention and the Health Resources Services Administration.

The information below indicates my desire and willingness to be selected as a member in the Nebraska HIV CARE & Prevention Consortium (NHCPC).

Name:	**Day Phone:**
Address:	**Home Phone:**
City: **Zip:**	**Fax:**
Employer:	**Email:**

The above mailing address is my **Home:** **Office:**

Please put an **X** in the box next to your response on the items below.

Race / Ethnicity

	White (non-Hispanic)		Hispanic / Latino/a
	African American / Black		Middle Eastern
	Asian / Pacific Islander		Other
	Native American / American Indian		

Age

	10 - 19
	20 - 29
	30 - 39
	40 - 49
	50 or above

Gender

	Male
	Female
	Transgender

Group Representation Position Applying For

(No more than two. **Please note 1st and 2nd choices.**)

Refer to attached form for group representation definitions.

	CTR / PCRS – HHS funded (Counseling / Testing)		MSM – Minority / Person of Color
	Prevention Subgrantee – HHS funded		Woman – HIV Impacted
	HIV Case Management – HHS funded		Injecting Drug User
	Minority Community Based Organization		Person Living with HIV or AIDS
	Minority – HIV Impacted		Mental Health / Substance Abuse Provider
	City / County / District Health Department		Business
	MSM - Rural		Native American / American Indian
	MSM - Urban		Minority Faith-Based

I am qualified to represent these positions because:

Choice #1:
Choice #2:

(Please continue on the back)

I have been involved with HIV/AIDS issues in the following areas:

I am interested in becoming a member of the NHCPC because:

I am able to participate/commit up to 15 hours per quarter and travel to meetings in Lincoln for the NHCPC.			
	Yes		No

I am willing to serve a three (3) year term with the NHCPC.			
	Yes		No

Disclosure of Conflict of Interest

Persons who may become members of the Nebraska HIV Care and Prevention Consortium (NHCPC) may be affiliated with organizations that have or may request funds for HIV prevention and/or care activities. Because of this potential for conflict of interest, this disclosure information is being requested.

I and/or a family member currently is, or has been within the past 12 months, a staff member, consultant, officer, board member, or in an advisory capacity with the following organizations:

1) Organization:	
Title:	Period of Affiliation:

2) Organization:	
Title:	Period of Affiliation:

Signature:	**Date:**

PLEASE PRINT AND MAIL TO:

Cheryl Bullard
HHS – HIV Prevention Program
PO Box 95044
Lincoln NE 68509-5044

OR SAVE AND E-MAIL AS AN ATTACHMENT TO:

cheryl.bullard@hhss.ne.gov